Insurance and Banking Committee 1

Amendment No. 2 to HB1554

McManus
Signature of Sponsor

AMEND Senate Bill No. 1991 House Bill No. 1554*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-3102, is amended by adding the following appropriately designated subdivisions:

( ) "Maximum allowable cost list" means a list of drugs, medical products or devices, or both medical products and devices, for which a maximum allowable cost has been established by a pharmacy benefits manager or covered entity;

( ) "Maximum allowable cost" means the maximum amount that a pharmacy benefits manager or covered entity will reimburse a pharmacy for the cost of a drug or a medical product or device;

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 31, is amended by adding the following new sections thereto:

56-7-3106.

(a) Before a pharmacy benefits manager or covered entity may place a drug on a maximum allowable cost list, the pharmacy benefits manager or covered entity must find that the drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler.

(b) If a drug that has been placed on a maximum allowable cost list no longer meets the requirements of subsection (a), the drug shall be removed from the maximum allowable cost list by the pharmacy benefits manager or covered entity within five (5) business days after the date that the pharmacy benefits manager or covered entity becomes aware that the drug no longer meets the requirements of subsection (a).

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(c) Nothing in this part shall be construed as preventing a pharmacy benefits manager or covered entity from reimbursing claims for a generic drug at the previously determined maximum allowable cost even if the pharmacy benefits manager or covered entity reimburses for the equivalent brand name drug at the contracted brand rate after confirmation by a national or regional wholesaler and by the manufacturer that the generic drug is generally unavailable for purchase from a national or regional wholesaler.

56-7-3107.

(a) A pharmacy benefits manager or covered entity shall make available to each pharmacy with which the pharmacy benefits manager or covered entity has a contract and to each pharmacy included in a network of pharmacies served by a pharmacy services administrative organization with which the pharmacy benefits manager or covered entity has a contract, at the beginning of the term of a contract and upon renewal of a contract:

(1) The sources used to determine the maximum allowable costs for the drugs and medical products and devices on each maximum allowable cost list;

(2) Every maximum allowable cost for individual drugs used by that pharmacy benefits manager or covered entity for patients served by that contracted pharmacy; and

(3) Upon request, every maximum allowable cost list used by that pharmacy benefits manager or covered entity for patients served by that contracted pharmacy.

(b) A pharmacy benefits manager or covered entity shall:

(1) Update each maximum allowable cost list at least every three (3) business days, as required by § 56-7-3104(b);

(2) Make the updated lists available to every pharmacy with which the pharmacy benefits manager or covered entity has a contract and to every pharmacy included in a network of pharmacies served by a pharmacy services administrative organization with which the pharmacy benefits manager or covered entity has a contract, in a readily accessible, secure and usable web-based format or other comparable format or process; and

(3) Utilize the updated maximum allowable costs to calculate the payments made to the contracted pharmacies within five (5) business days.

56-7-3108.

(a) A pharmacy benefits manager or covered entity shall establish a clearly defined process through which a pharmacy may contest the listed maximum allowable cost for a particular drug or medical product or device.

(b) A pharmacy may base its appeal on one (1) or more of the following:

(1) The maximum allowable cost established for a particular drug or medical product or device is below the cost at which the drug or medical product or device is generally available for purchase by pharmacies in this state from national or regional wholesalers; or

(2) The pharmacy benefits manager or covered entity has placed a drug on the list without properly determining that the requirements of § 56-7-3106 have been met.

(c) The pharmacy must file its appeal within seven (7) business days of its submission of the initial claim for reimbursement for the drug or medical product or device. The pharmacy benefits manager or covered entity must make a final determination resolving the pharmacy's appeal within seven (7) business days of the pharmacy benefits manager or covered entity's receipt of the appeal.

(d) If the final determination is a denial of the pharmacy's appeal, the pharmacy benefits manager or covered entity must state the reason for the denial and provide the national drug code of an equivalent drug that is generally available for purchase by pharmacies in this state from national or regional wholesalers at a price which is equal to or less than the maximum allowable cost for that drug.

(e)

(1) If a pharmacy's appeal is determined to be valid by the pharmacy benefits manager or covered entity, the pharmacy benefits manager or covered entity shall adjust the maximum allowable cost of the drug or medical product or device for the appealing pharmacy. The adjustment for the appealing pharmacy shall be effective from the date the pharmacy's appeal was filed, and the pharmacy benefits manager or covered entity shall provide reimbursement to the appealing pharmacy and may require the appealing pharmacy to reverse and rebill the claim in question in order to receive the corrected reimbursement.

(2) Once an appealing pharmacy's appeal is determined to be valid by the pharmacy benefits manager or covered entity, the pharmacy benefits manager or covered entity shall adjust the maximum allowable cost of the drug or medical product or device to which the maximum allowable cost applies for all similar pharmacies in the network as determined by the pharmacy benefits manager within three (3) business days for claims submitted in the next payment cycle.

(f) A pharmacy benefits manager or covered entity shall make available on its secure web site information about the appeals process, including, but not limited to, a telephone number or process that a pharmacy may use to submit maximum allowable cost appeals.

56-7-3109. The medical products and devices subject to the requirements of this part are limited to the medical products and devices included as a pharmacy benefit under the pharmacy benefits contract.

56-7-3110. A violation of this part may subject the pharmacy benefits manager or covered entity to any of the sanctions described in § 56-2-305.

56-7-3111. A pharmacy shall not disclose to any third party the maximum allowable cost lists and any related information it receives from a pharmacy benefits manager or covered entity; provided, however, a pharmacy may share such lists and related information with a pharmacy services administrative organization or similar entity with which the pharmacy has a contract to provide administrative services for that pharmacy. If a pharmacy shares this information with a pharmacy services administrative organization or similar entity, that organization or entity shall not disclose the information to any third party.

SECTION 3. This act shall take effect January 1, 2015, the public welfare requiring it, and shall apply to all contracts entered into or renewed on or after that date.